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Changes in Premature Mortality — New York City

Between 1982 and 1984, major changes occurred in mortality patterns of New York City residents aged 15-64 years. Among males in the study group, the mortality rate increased 4%, from 657 to 683 deaths per 100,000 population, and the total years of potential life lost before age 65 years (YPLL) increased 7%. Among females, the mortality rate increased 1%, from 329 to 333/100,000, and the YPLL increased 5%. Before 1982, mortality rates and YPLL had steadily declined for at least 7 years.

The underlying causes of death were classified according to the International Classification of Diseases, 9th Revision (ICD-9), with the exception of acquired immunodeficiency syndrome (AIDS) (Table 1). The classification of AIDS required either a death certificate with the underlying cause of death listed as AIDS (code 279.1) or a death certificate that matched the New York City AIDS surveillance registry. For both sexes, the largest increases in YPLL were due to AIDS and to pneumonia and influenza (P&I). Among males, there was a 14% increase in

TABLE 1. Years of potential life lost (YPLL) before age 65 years and deaths, death rates, and change in YPLL, by sex and by cause of death — New York City, 1984

Cause*	YPLL	No. deaths	Death rate†	Change in YPLL from 1982 (%)
Males				
Homicide and suicide (E950-E978)	47,900	1,531	70	-14
Heart diseases (390-98, 402, 404-29)	41,600	4,166	191	-2
Malignant neoplasm (140-208)	33,900	3,031	139	+5
AIDS (279.1 and registry matches)	24,400	923	42	+510
Chronic liver disease and cirrhosis (571)	18,700	1,007	46	-3
Accidents (E800-E949)	11,600	441	20	-19
Pneumonia and influenza (480-87)	8,900	481	22	+86
Cerebrovascular disease (430-38)	5,800	409	19	+14
All causes	252,100	14,939	683	+8
Females				
Malignant neoplasms (140-208)	34,700	2,971	119	-1
Heart diseases (390-98, 402, 404-29)	19,100	2,145	86	+3
Homicide and suicide (E950-E978)	10,200	348	14	+4
Chronic liver disease and cirrhosis (571)	6,400	370	15	+3
Cerebrovascular disease (430-38)	4,500	337	14	-5
AIDS (279.1 and registry matches)	4,300	132	5	+1,000
Pneumonia and influenza (480-87)	4,200	213	9	+71
Accidents (E800-E949)	2,900	441	5	-34
All causes	166,800	8,334	333	+1

*Codes are those of the International Classification of Diseases, 9th Revision.

†Per 100,000 population.

Premature Mortality — Continued

YPLL due to cerebrovascular disease; and among females, a 5% decrease. Large decreases in YPLL were due to external causes of death: for men, a 14% decrease due to homicide and suicide and a 19% decrease due to accidents; for women, a 4% increase due to homicide and suicide and a 34% decrease due to accidents. Other leading causes of YPLL did not change markedly.

The main difference between the leading causes of death in 1984 and 1982 is the addition of AIDS. Since 1980, AIDS has become the sixth leading cause of YPLL for women in New York City and the fourth leading cause for men. In 1984, AIDS was the underlying cause of death for 923 men and 132 women, accounting for 10% and 4%, respectively, of premature mortality in New York City (Figure 1).

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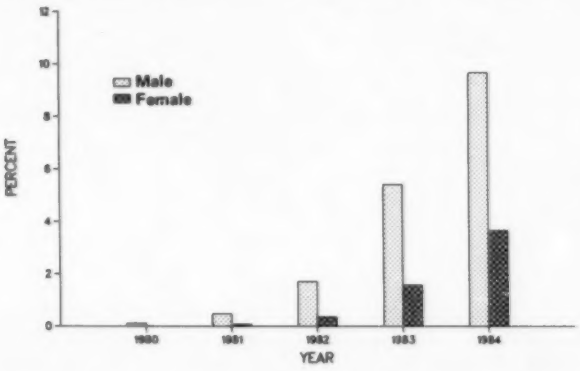
Editorial Note: YPLL highlights premature deaths compared with measures of crude mortality by giving greater weight to deaths occurring in younger age groups (*1*). YPLL can be used at the community or state level to identify localized patterns of premature mortality and to quantify the relative local importance of individual causes of mortality. Differences in sex- and race-specific rates of YPLL may also distinguish particular population subgroups at increased risk of premature death.

The relative ranking of specific causes of premature mortality in the United States as a whole differs markedly from that of New York City, but the increasing importance of AIDS is evident in national data. Information from AIDS cases reported to CDC indicates about 11,000 years of potential life lost in the United States due to AIDS in 1982, 34,000 in 1983, and 74,000 in 1984. Although AIDS was not one of the top 15 causes of premature mortality nationally in 1984, it may emerge as a leading cause in 1985 if present patterns of YPLL for other causes remain constant and YPLL were to double along with case projections.

The decreases in YPLL due to unintentional injuries and suicide/homicide are consistent with trends in national data, with injuries decreasing 5% and suicide/homicide decreasing 7% from 1982 to 1984. YPLL from cerebrovascular diseases, however, has increased 1% from 1982 to 1984.

FIGURE 1. Years of potential life lost (YPLL) before age 65 years due to AIDS, as percent of total YPLL to all causes, by sex and year — New York City, 1980-1984



Premature Mortality — Continued

The cause of the increase in YPLL due to P&I is uncertain but may in part be related to AIDS. Although *Pneumocystis carinii* pneumonia (which meets the CDC AIDS case definition) is not included in the ICD-9 rubric used to specify the P&I category, unspecified pneumonia would be included and may reflect undiagnosed or unreported AIDS cases. Continued study will be necessary to clarify the cause of this increase in YPLL associated with P&I.

Reference

1. CDC. Changes in premature mortality—United States, 1982-1983. MMWR 1985;34:17-8.

Respiratory Syncytial Virus Outbreak at an Institution for the Mentally Retarded — Washington

In March and April 1985, two distinct outbreaks of febrile respiratory illness caused by respiratory syncytial virus (RSV) were reported in a residential institution for the mentally retarded in northern Seattle-King County, Washington. Investigation of these outbreaks began when four of 25 ill residents required hospitalization and one died. The 496 residents, aged 4-85 years, were housed in large dormitory living units or smaller apartment units. The two dormitories involved in this outbreak, Hall A (32 residents with a mean age of 20 years) and Hall B (16 residents with a mean age of 19 years), served the most severely handicapped, who were often nonambulatory and had severe physical handicaps. The south wing of Hall B contained the infirmary, which served the entire institution.

The investigation of the outbreak in Hall A was undertaken March 22-25. Demographic and illness data, nasopharyngeal swabs, and convalescent sera were obtained from all of 32 residents, seven of 22 staff, and four classroom contacts of residents of the hall. Acute sera were also obtained from 11 residents.

The first resident became ill March 7 and was hospitalized the next day for wheezing and respiratory distress. She had traveled to athletic games on March 2 with a staff member, not from Hall A, who had rhinorrhea. During the outbreak, 16 of 32 residents became ill with fever of 38.0 C (100.4 F) or higher and either wheezing or upper respiratory symptoms (rhinorrhea, cough, or both). Of these 16, 13 had upper respiratory symptoms; eight, wheezing; five, otitis media; two, gastrointestinal symptoms; two, respiratory distress; and one, bronchopneumonia. Duration of illness was 2-17 days (mean 9 days). Four patients were hospitalized: one for 6 days and two for 5 days each, and one died with respiratory distress on her fourth hospital day. Two of these four had histories of asthma, and the patient who died had a history of multiple aspiration pneumonias. Three of the 16 ill residents, including the index patient, were both culture- and immunofluorescence (FA)-positive for RSV. The patient who died was FA-positive only. Three of seven staff members also had respiratory symptoms, and one was culture- and FA-positive for RSV. Age, sex, reason for handicap, preexisting respiratory illness, wing of dormitory residence, and age when institutionalized were comparable between ill and well residents. The mean age of ill residents was 17 years, and of well residents, 22 years. The mean duration of institutionalization (5.6 years for ill and 12.7 years for well residents) and mean length of residence at this institution (3.9 years for ill and 11.1 years for well residents) were increased in well residents.

Control measures included good hand-washing practices by staff, confining ill residents to their residences for the duration of their symptoms, and cohorting ill or exposed staff with ill or exposed residents. When possible, ill residents were placed in one wing of Hall A and well

RSV Outbreak – Continued

residents in the other, and separate staff members were assigned to each wing. Gloves, masks, and gowns were used by staff while caring for ill residents.

A similar investigation was performed in Hall B on April 18. Beginning April 6, 11 days after onset of the last case in Hall A, eight of 16 residents became ill with fever of 38.0 C (100.4 F) or higher and either wheezing or upper respiratory symptoms. The index patient in Hall B had no contacts in Hall A, but had been hospitalized for tracheostomy repair March 31-April 3 in a facility where RSV was known to be present. Of the eight ill patients, one was culture- and FA-positive for RSV, and another was culture-positive and FA-negative. All had upper respiratory symptoms; four, chest congestion; two, wheezing; and two, otitis media. None were hospitalized.

Sex, presence of preexisting respiratory disease, and reason for handicap were not associated with illness. Ill residents were younger than well residents (11.3, compared with 28.4 years) and had been institutionalized for a shorter time (6.2, compared with 19.3 years). Control measures similar to those used for Hall A were observed. Serologic results are pending from both halls.

(Continued on page 677)

TABLE I. Summary—cases of specified notifiable diseases, United States

Disease	44th Week Ending			Cumulative, 44th Week Ending		
	Nov. 2, 1985	Nov. 3, 1984	Median 1980-1984	Nov. 2, 1985	Nov. 3, 1984	Median 1980-1984
Acquired Immunodeficiency Syndrome (AIDS)	125	167	N	6,693	3,577	N
Aseptic meningitis	298	195	268	8,406	6,930	8,044
Encephalitis: Primary (arthropod-borne & unspec.)	36	44	40	1,033	1,018	1,305
Post-infectious	1	2	2	107	101	80
Gonorrhea: Civilian	15,507	17,080	19,341	713,357	712,627	813,053
Military	222	295	397	15,294	18,132	22,397
Hepatitis: Type A	556	508	455	19,156	18,089	19,250
Type B	536	615	481	22,048	21,913	18,267
Non A, Non B	90	96	N	3,468	3,211	N
Unspecified	132	120	139	4,873	4,308	7,303
Legionellosis	20	22	N	552	589	N
Leprosy	14	1	3	301	195	195
Malaria	19	56	26	868	850	916
Measles: Total*	14	8	14	2,578	2,434	2,434
Indigenous	14	4	N	2,144	2,148	N
Imported	-	4	N	434	286	N
Meningococcal infections: Total	48	27	46	2,004	2,284	2,322
Civilian	47	27	46	2,000	2,280	2,307
Military	1	-	-	4	4	14
Mumps	53	37	68	2,504	2,517	3,752
Pertussis	48	36	31	2,672	2,034	1,456
Rubella (German measles)	2	8	18	572	662	1,883
Syphilis (Primary & Secondary): Civilian	417	535	679	21,611	23,618	26,181
Military	1	6	6	123	257	329
Toxic Shock syndrome	6	7	N	300	412	N
Tuberculosis	434	397	522	18,003	18,016	21,503
Tularemia	-	3	5	142	263	236
Typhoid fever	4	6	6	311	307	401
Typhus fever, tick-borne (RMSF)	11	12	10	653	789	1,066
Rabies, animal	89	111	105	4,544	4,654	5,407

TABLE II. Notifiable diseases of low frequency, United States

	Cum. 1985		Cum. 1985
Anthrax	-	Leptospirosis (Ga. 1)	32
Botulism: Foodborne (N.C. 1)	43	Plague	13
Infant (Kans. 1, Calif. 2)	50	Poliomyelitis: Total	5
Other	1	Paralytic	5
Brucellosis (Kans. 1)	116	Psittacosis (Minn. 1, Iowa 1)	92
Cholera	3	Rabies, human	1
Congenital rubella syndrome	-	Tetanus (Ala. 1)	57
Congenital syphilis, ages < 1 year	149	Trichinosis	51
Diphtheria	1	Typhus fever, flea-borne (endemic, murine)	20

*There were no cases of internationally imported measles reported for this week.

TABLE III. Cases of specified notifiable diseases, United States, weeks ending November 2, 1985 and November 3, 1984 (44th Week)

Reporting Area	AIDS	Aseptic Meningitis	Encephalitis		Gonorrhea (Civilian)		Hepatitis (Viral), by type				Legionellosis	Leprosy
			Primary	Post-infectious			A	B	NA,NB	Unspecified		
	Cum. 1985	1985	Cum. 1985	Cum. 1985	Cum. 1985	Cum. 1984	1985	1985	1985	1985	1985	Cum 1985
UNITED STATES	6,693	298	1,033	107	713,357	712,627	556	536	90	132	20	301
NEW ENGLAND	233	28	27	-	19,215	19,468	10	27	3	9	1	6
Maine	10	1	-	-	978	848	-	2	-	-	-	-
N.H.	2	-	7	-	486	619	-	-	-	-	-	-
Vt.	2	8	-	-	282	321	1	-	-	-	-	-
Mass.	138	13	16	-	7,898	8,352	8	16	2	8	1	6
R.I.	12	3	-	-	1,517	1,379	-	5	1	1	-	-
Conn.	69	3	4	-	8,054	7,949	1	4	-	-	-	-
MID ATLANTIC	2,618	68	130	11	108,249	95,372	30	41	7	9	-	33
Upstate N.Y.	294	17	40	4	15,313	15,262	6	7	4	1	-	1
N.Y. City	1,774	6	14	-	52,666	37,289	-	-	-	-	-	28
N.J.	392	21	27	-	16,312	16,710	7	7	3	2	-	-
Pa.	158	24	49	7	23,958	26,111	17	27	-	6	-	4
E.N. CENTRAL	285	47	278	20	99,508	100,179	24	44	5	7	11	21
Ohio	45	13	129	4	26,614	26,084	11	16	-	2	1	3
Ind.	23	4	62	2	11,061	11,051	1	5	-	1	7	-
Ill.	146	-	14	8	23,832	22,315	6	5	2	2	-	16
Mich.	51	30	54	-	28,398	29,562	6	18	3	2	3	2
Wis.	20	-	19	6	9,603	11,167	-	-	-	-	-	-
W.N. CENTRAL	91	13	70	4	35,221	35,154	26	8	-	-	1	2
Minn.	29	12	33	1	5,246	5,295	1	-	-	-	-	1
Iowa	10	-	26	-	3,715	3,808	8	2	-	-	1	-
Mo.	39	-	-	-	16,978	16,909	1	6	-	-	-	1
N. Dak.	-	-	-	1	236	333	-	-	-	-	-	-
S. Dak.	1	-	-	-	676	878	13	-	-	-	-	-
Nebr.	3	-	5	-	3,031	2,502	-	-	-	-	-	-
Kans.	9	1	6	2	5,339	5,479	3	-	-	-	-	-
S. ATLANTIC	1,016	54	121	42	158,239	180,936	33	124	12	5	5	7
Del.	10	2	7	-	3,750	3,366	-	1	-	-	-	-
Md.	119	13	25	1	24,889	20,456	4	13	1	-	-	1
D.C.	148	-	-	-	13,273	12,952	1	-	-	-	-	-
Va.	85	5	25	6	16,512	17,089	1	11	3	-	-	-
W. Va.	5	2	33	-	2,231	2,251	2	5	-	-	1	-
N.C.	54	13	26	1	31,209	29,275	3	24	3	-	2	2
S.C.	24	1	5	-	18,747	18,402	-	18	-	-	1	-
Ga.	140	2	-	-	-	33,325	3	16	1	-	1	1
Fla.	431	16	-	34	47,628	43,820	19	36	4	5	-	3
E.S. CENTRAL	60	32	36	4	64,994	64,385	6	41	7	2	1	-
Ky.	15	14	17	-	7,443	7,715	3	8	1	-	1	-
Tenn.	16	3	6	-	24,851	25,981	1	20	-	1	-	-
Ala.	23	14	11	4	19,452	19,544	2	11	6	1	-	-
Miss.	6	1	2	-	13,248	11,145	-	2	-	-	-	-
W.S. CENTRAL	488	20	129	2	95,036	96,950	60	58	6	22	-	24
Ark.	6	-	4	1	9,114	8,971	-	-	-	-	-	1
La.	79	-	8	-	18,142	21,166	1	7	-	-	-	6
Okla.	15	1	23	1	10,601	10,598	5	7	2	3	-	-
Tex.	388	19	94	-	57,179	56,215	54	44	4	29	-	17
MOUNTAIN	124	3	40	6	23,700	23,509	70	46	6	13	1	8
Mont.	1	-	-	-	683	901	8	6	-	1	-	-
Idaho	-	-	-	-	822	1,117	7	-	-	-	-	-
Wyo.	-	-	1	-	539	631	-	-	-	-	-	-
Colo.	45	-	6	2	6,891	6,774	8	4	2	4	-	2
N. Mex.	12	-	3	-	2,689	2,850	5	5	-	-	-	-
Ariz.	44	2	17	-	7,032	6,469	31	24	3	8	-	1
Utah	13	1	10	4	1,145	1,115	2	2	-	-	1	3
Nev.	9	-	3	-	3,899	3,652	9	5	1	-	-	2
PACIFIC	1,778	31	202	18	109,195	96,674	297	147	44	55	-	200
Wash.	93	3	13	1	8,376	7,610	29	16	9	1	-	34
Oreg.	29	-	1	-	5,526	5,676	55	10	4	-	-	3
Calif.	1,635	23	152	17	91,181	79,286	212	119	31	54	-	143
Alaska	3	-	36	-	2,633	2,428	-	-	-	-	-	-
Hawaii	18	5	-	-	1,479	1,674	1	2	-	-	-	20
Guam	1	U	-	-	128	202	U	U	U	U	U	3
P.R.	70	18	5	2	2,680	2,893	20	17	-	12	-	2
V.I.	2	U	-	-	353	459	U	U	U	U	U	-
Pac. Trust Terr.	-	U	-	-	146	-	U	U	U	U	U	20

N: Not notifiable U: Unavailable

TABLE III. (Cont'd.) Cases of specified notifiable diseases, United States, weeks ending November 2, 1985 and November 3, 1984 (44th Week)

Reporting Area	Malaria	Measles (Rubeola)					Menin-gococcal Infections	Mumps		Pertussis			Rubella		
		Indigenous		Imported *		Total									
	Cum. 1985	1985	Cum. 1985	1985	Cum. 1985	Cum. 1984	Cum. 1985	1985	Cum. 1985	1985	Cum. 1985	Cum. 1984	1985	Cum. 1985	Cum. 1984
UNITED STATES	868	14	2,144	-	434	2,434	2,004	53	2,504	48	2,672	2,034	2	572	662
NEW ENGLAND	51	-	38	-	88	106	91	-	58	5	192	66	-	12	18
Maine	4	-	-	-	1	-	4	-	6	-	13	2	-	-	1
N.H.	4	-	-	-	-	36	14	-	10	-	103	17	-	2	1
Vt.	1	-	-	-	-	7	10	-	3	-	3	23	-	-	-
Mass.	25	-	34	-	84	49	16	-	17	1	46	17	-	6	16
R.I.	6	-	-	-	-	-	14	-	15	3	19	3	-	-	-
Conn.	11	-	4	-	3	14	33	-	7	1	8	4	-	4	-
MID ATLANTIC	137	7	185	-	38	159	350	13	292	7	174	176	-	219	221
Upstate N.Y.	47	-	72	-	13	38	133	2	152	3	80	98	-	17	99
N.Y. City	52	1	59	-	12	109	60	-	32	2	23	7	-	179	103
N.J.	14	-	17	-	10	7	57	8	46	-	11	13	-	9	18
Pa.	24	6	37	-	3	5	100	3	62	2	60	58	-	14	1
E.N. CENTRAL	57	-	435	-	90	696	349	9	879	12	569	474	2	32	91
Ohio	9	-	-	-	54	9	113	5	262	7	96	72	-	-	2
Ind.	4	-	55	-	2	3	44	-	37	-	186	229	-	1	5
Ill.	21	-	286	-	10	180	80	2	190	3	46	26	2	15	55
Mich.	17	-	37	-	23	464	84	2	308	2	46	28	-	15	21
Wis.	6	-	57	-	1	40	28	-	82	-	193	119	-	1	8
W.N. CENTRAL	30	1	2	-	10	56	102	3	77	4	212	120	-	19	39
Minn.	14	-	-	-	6	47	25	-	1	4	108	15	-	2	4
Iowa	2	-	-	-	-	-	10	2	16	-	28	12	-	1	1
Mo.	5	1	1	-	2	4	40	1	13	-	28	20	-	7	-
N. Dak.	2	-	-	-	2	-	5	-	4	-	9	-	-	2	3
S. Dak.	1	-	-	-	-	-	3	-	-	-	3	9	-	-	-
Nebr.	1	-	-	-	-	-	8	-	3	-	8	12	-	-	-
Kans.	5	-	1	-	-	5	11	-	40	-	28	52	-	7	31
S. ATLANTIC	102	3	278	-	30	66	384	8	242	5	366	205	-	55	24
Del.	-	-	-	-	-	-	10	-	1	-	2	2	-	1	-
Md.	24	3	104	-	9	22	53	1	33	4	155	61	-	6	1
D.C.	8	-	9	-	1	8	6	-	-	-	1	-	-	-	-
Va.	20	-	21	-	7	5	47	2	45	-	17	19	-	2	-
W. Va.	2	-	31	-	2	-	8	-	65	-	4	11	-	9	-
N.C.	9	-	9	-	-	1	53	2	17	-	30	33	-	1	-
S.C.	-	-	-	-	3	1	34	-	11	-	2	2	-	3	-
Ga.	9	-	8	-	-	2	66	-	28	1	93	17	-	4	2
Fla.	30	-	96	-	8	27	107	3	42	-	62	60	-	29	21
E.S. CENTRAL	11	-	-	-	7	6	91	-	29	5	55	14	-	3	12
Ky.	4	-	-	-	5	1	9	-	8	-	8	2	-	3	6
Tenn.	-	-	-	-	1	2	35	-	17	4	24	7	-	-	-
Ala.	6	-	-	-	-	3	26	-	1	1	19	1	-	-	3
Miss.	1	-	-	-	1	-	21	-	3	-	4	4	-	-	3
W.S. CENTRAL	80	2	420	-	16	565	170	10	279	-	479	309	-	37	54
Ark.	3	-	-	-	-	8	15	-	6	-	14	19	-	1	3
La.	1	-	42	-	-	8	25	-	2	-	15	8	-	-	-
Okla.	5	-	-	-	1	8	31	N	N	-	154	241	-	1	-
Tex.	71	2	378	-	15	541	99	10	271	-	296	41	-	35	51
MOUNTAIN	46	-	497	-	51	145	91	1	230	6	201	112	-	5	21
Mont.	-	-	122	-	17	-	12	-	11	-	9	19	-	-	-
Idaho	2	-	126	-	18	23	4	-	9	-	7	7	-	1	1
Wyo.	1	-	5	-	-	-	6	-	2	-	-	6	-	-	2
Colo.	14	-	6	-	7	6	22	1	24	6	83	39	-	-	2
N. Mex.	14	-	1	-	5	88	10	N	N	-	12	9	-	2	1
Ariz.	10	-	237	-	4	1	22	-	113	-	38	13	-	1	4
Utah	2	-	-	-	-	27	9	-	6	-	52	7	-	-	7
Nev.	3	-	-	-	-	-	6	-	65	-	-	2	-	1	4
PACIFIC	354	1	289	-	104	635	376	9	418	4	424	558	-	190	182
Wash.	23	-	79	-	39	154	65	1	35	1	75	314	-	14	1
Oreg.	12	-	4	-	1	-	34	N	N	-	44	30	-	1	2
Calif.	300	1	188	-	59	318	264	8	356	3	258	138	-	132	173
Alaska	2	-	-	-	-	-	9	-	9	-	30	1	-	1	1
Hawaii	17	-	18	-	5	163	4	-	18	-	17	75	-	42	5
Guam	1	U	10	U	1	90	-	U	5	U	-	-	U	2	4
P.R.	-	-	83	-	-	17	13	6	145	-	11	1	-	27	16
V.I.	-	U	4	U	6	-	-	U	3	U	-	-	U	-	-
Pac. Trust Terr.	-	U	-	U	-	-	-	U	3	U	-	-	U	-	-

*For measles only, imported cases includes both out-of-state and international importations.

N: Not notifiable U: Unavailable †International §Out-of-state

TABLE III. (Cont'd.) Cases of specified notifiable diseases, United States, weeks ending November 2, 1985 and November 3, 1984 (44th Week)

Reporting Area	Syphilis (Civilian) (Primary & Secondary)		Toxic-shock Syndrome	Tuberculosis		Tula-remia	Typhoid Fever	Typhus Fever (Tick-borne) (RMSF)	Rabies, Animal
	Cum. 1985	Cum. 1984	1985	Cum. 1985	Cum. 1984	Cum. 1985	Cum. 1985	Cum. 1985	Cum. 1985
UNITED STATES	21,611	23,618	6	18,003	18,016	142	311	653	4,544
NEW ENGLAND	499	458	-	619	547	3	12	8	20
Maine	13	8	-	39	27	-	-	-	-
N.H.	36	14	-	19	25	-	-	1	1
Vt.	5	1	-	7	7	-	-	-	1
Mass.	248	261	-	370	304	3	9	6	11
R.I.	14	19	-	47	45	-	-	1	-
Conn.	183	155	-	137	139	-	3	-	7
MID ATLANTIC	3,061	3,146	1	3,203	3,243	2	47	34	512
Upstate N.Y.	234	287	-	589	506	-	12	9	119
N.Y. City	1,842	1,897	1	1,527	1,310	1	24	5	-
N.J.	598	557	-	453	725	1	10	4	39
Pa.	387	405	-	654	702	-	1	16	354
E.N. CENTRAL	870	1,119	1	2,205	2,339	2	38	39	167
Ohio	128	199	-	374	424	-	10	27	29
Ind.	74	120	-	271	274	-	3	4	23
Ill.	400	406	-	965	970	1	16	6	36
Mich.	210	328	1	474	528	-	7	2	25
Wis.	58	66	-	121	143	1	2	-	54
W.N. CENTRAL	198	318	1	500	545	43	13	42	834
Minn.	39	84	-	108	92	1	6	-	161
Iowa	18	11	1	51	56	-	3	1	135
Mo.	107	158	-	237	270	28	3	8	46
N. Dak.	3	9	-	9	12	-	-	1	121
S. Dak.	6	-	-	27	21	8	-	2	294
Nebr.	6	15	-	12	29	2	1	3	33
Kans.	19	41	-	56	65	4	-	27	44
S. ATLANTIC	5,354	6,943	-	3,675	3,759	6	35	307	1,155
Del.	34	18	-	38	47	1	-	3	1
Md.	369	433	-	332	352	-	11	26	575
D.C.	286	280	-	133	151	-	-	-	-
Va.	256	353	-	357	373	1	3	23	161
W. Va.	22	16	-	95	120	-	1	1	27
N.C.	588	720	-	471	572	4	4	128	11
S.C.	691	664	-	451	451	-	1	69	61
Ga.	-	1,189	-	612	580	-	3	48	182
Fla.	3,108	3,270	-	1,186	1,113	-	12	9	137
E.S. CENTRAL	1,866	1,714	-	1,579	1,698	8	5	73	218
Ky.	59	87	-	384	398	-	1	13	31
Tenn.	528	449	-	470	496	6	2	32	64
Ala.	571	566	-	464	501	1	2	14	117
Miss.	708	612	-	261	303	1	-	14	6
W.S. CENTRAL	5,267	5,768	1	2,320	2,133	55	28	133	743
Ark.	284	188	-	268	243	33	-	16	123
La.	938	1,044	-	335	299	-	1	4	19
Okla.	163	185	1	220	202	16	2	90	95
Tex.	3,882	4,351	-	1,497	1,389	6	25	23	506
MOUNTAIN	605	536	2	475	482	15	11	14	383
Mont.	6	3	-	46	17	4	-	6	193
Idaho	5	21	-	22	27	-	-	-	10
Wyo.	8	7	-	5	3	-	-	4	18
Colo.	156	145	-	67	55	2	4	2	24
N. Mex.	112	77	-	76	94	2	4	-	11
Ariz.	273	185	-	219	222	4	3	-	112
Utah	8	18	2	12	33	3	-	-	4
Nev.	37	80	-	28	31	-	-	2	11
PACIFIC	3,891	3,616	-	3,427	3,270	8	122	3	512
Wash.	80	134	-	207	170	-	1	-	4
Oreg.	88	100	-	115	135	1	5	-	4
Calif.	3,663	3,306	-	2,854	2,713	4	110	3	501
Alaska	4	6	-	90	64	3	2	-	3
Hawaii	56	70	-	161	188	-	4	-	-
Guam	2	-	U	30	47	-	-	-	-
P.R.	723	683	-	295	325	-	3	-	34
V.I.	3	10	U	1	4	-	52	-	-
Pac. Trust Terr.	13	-	U	16	-	-	-	-	-

U: Unavailable

TABLE IV. Deaths in 121 U.S. cities,* week ending November 2, 1985 (44th Week)

Reporting Area	All Causes, By Age (Years)						P&I** Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	616	447	109	38	9	13	55
Boston, Mass.	165	104	34	16	4	7	13
Bridgeport, Conn.	38	26	10	2	-	-	6
Cambridge, Mass.	27	20	5	2	-	-	7
Fall River, Mass.	29	24	4	1	-	-	-
Hartford, Conn.	42	32	9	1	-	-	-
Lowell, Mass.	27	21	5	1	-	-	3
Lynn, Mass.	20	17	2	1	-	-	1
New Bedford, Mass.	29	27	1	1	-	-	-
New Haven, Conn.	25	17	5	1	1	1	1
Providence, R.I.	70	54	7	5	3	1	9
Somerville, Mass.	15	12	2	1	-	-	3
Springfield, Mass.	46	30	10	4	1	1	3
Waterbury, Conn.	26	22	2	1	-	1	-
Worcester, Mass.	57	41	13	1	-	2	9
MID ATLANTIC	2,775	1,798	597	235	61	83	139
Albany, N.Y.	55	38	9	4	2	2	-
Allentown, Pa.	19	18	-	1	-	-	-
Buffalo, N.Y.	122	79	37	2	2	2	8
Camden, N.J.	28	14	8	3	-	3	1
Elizabeth, N.J.	28	23	3	1	1	-	-
Erie, Pa.†	42	30	8	2	2	-	2
Jersey City, N.J.	60	42	10	8	-	-	2
N.Y. City, N.Y.	1,463	904	313	170	26	50	64
Newark, N.J.	85	37	28	9	2	8	9
Paterson, N.J.	21	10	9	1	-	1	2
Philadelphia, Pa.	396	259	86	19	18	14	23
Pittsburgh, Pa.†	77	52	18	3	3	1	2
Reading, Pa.	27	22	3	1	1	-	5
Rochester, N.Y.	99	83	9	4	2	1	8
Schenectady, N.Y.	33	24	6	3	-	-	4
Scranton, Pa.†	33	26	6	1	-	-	2
Syracuse, N.Y.	95	71	21	1	1	1	2
Trenton, N.J.	41	27	11	2	1	-	-
Utica, N.Y.	25	17	8	-	-	-	3
Yonkers, N.Y.	26	22	4	-	-	-	1
E.N. CENTRAL	2,329	1,656	380	135	63	94	85
Akron, Ohio	57	43	9	1	3	1	-
Canton, Ohio	40	32	5	1	2	-	2
Chicago, Ill.§	553	462	11	26	16	37	16
Cincinnati, Ohio	156	107	37	6	3	3	12
Cleveland, Ohio	168	104	41	12	6	5	5
Columbus, Ohio	132	84	22	9	9	8	6
Dayton, Ohio	98	66	18	11	1	2	2
Detroit, Mich.	268	170	53	28	11	6	5
Evansville, Ind.	47	32	11	2	2	-	2
Fort Wayne, Ind.	56	40	8	4	-	4	3
Gary, Ind.	20	12	6	2	-	-	1
Grand Rapids, Mich.	44	34	8	-	-	2	2
Indianapolis, Ind.	170	110	37	7	5	11	3
Madison, Wis.	43	28	11	2	-	2	4
Milwaukee, Wis.	156	104	36	9	1	6	6
Peoria, Ill.	52	38	10	3	-	1	2
Rockford, Ill.	47	31	11	3	-	2	-
South Bend, Ind.	43	32	6	3	2	-	5
Toledo, Ohio	106	73	26	4	1	2	5
Youngstown, Ohio	73	54	14	2	1	2	4
W.N. CENTRAL	762	542	137	42	15	26	44
Des Moines, Iowa	73	53	14	4	1	1	9
Duluth, Minn.	38	31	3	3	1	-	-
Kansas City, Kans.	31	17	7	3	3	1	1
Kansas City, Mo.	132	90	28	9	-	5	9
Lincoln, Nebr.	30	24	6	-	-	-	2
Minneapolis, Minn.	87	60	14	5	2	6	4
Omaha, Nebr.	75	50	16	2	3	4	2
St. Louis, Mo.	151	109	25	10	4	3	7
St. Paul, Minn.	68	53	12	1	-	2	2
Wichita, Kans.	77	55	12	5	1	4	8
S. ATLANTIC	1,243	779	286	102	43	33	47
Atlanta, Ga.	174	89	48	24	7	6	1
Baltimore, Md.	246	138	74	20	10	4	11
Charlotte, N.C.	99	63	23	7	4	2	7
Jacksonville, Fla.	110	75	14	9	6	6	3
Miami, Fla.	116	77	26	8	4	1	-
Norfolk, Va.	62	31	18	7	-	6	2
Richmond, Va. §	79	72	1	2	1	3	5
Savannah, Ga.	59	37	15	7	-	-	5
St. Petersburg, Fla.	104	86	15	2	1	-	10
Tampa, Fla.	66	40	12	9	4	1	2
Washington, D.C.	101	55	32	6	4	4	1
Wilmington, Del.	27	16	8	1	2	-	-
E.S. CENTRAL	759	494	173	38	22	32	39
Birmingham, Ala.	131	77	37	3	6	8	2
Chattanooga, Tenn.	65	41	19	3	1	1	4
Knoxville, Tenn.	84	63	17	2	1	1	3
Louisville, Ky.	94	71	16	4	1	2	5
Memphis, Tenn.	151	102	24	12	6	7	9
Mobile, Ala.	62	34	20	5	-	3	7
Montgomery, Ala.	37	26	7	-	1	3	2
Nashville, Tenn.	135	80	33	9	6	7	7
W.S. CENTRAL	1,206	677	319	125	46	38	62
Austin, Tex.	61	29	18	8	6	-	7
Baton Rouge, La.	40	25	13	1	1	-	2
Corpus Christi, Tex.§	46	41	-	2	1	2	-
Dallas, Tex.	190	95	51	29	8	7	9
El Paso, Tex.	89	36	22	7	1	3	3
Fort Worth, Tex.	84	47	22	6	6	2	5
Houston, Tex.	281	157	73	35	9	7	8
Little Rock, Ark.	73	40	18	6	4	5	8
New Orleans, La.	97	52	28	13	2	2	-
San Antonio, Tex.	166	97	42	14	6	7	16
Shreveport, La.	22	15	5	1	-	1	-
Tulsa, Okla.	77	43	27	3	2	2	4
MOUNTAIN	573	344	129	45	33	21	31
Albuquerque, N.Mex.	83	53	12	10	4	4	1
Colo. Springs, Colo.	23	12	7	2	1	1	2
Denver, Colo.	126	80	21	8	11	6	7
Las Vegas, Nev.	75	40	25	6	4	-	6
Ogden, Utah	24	15	3	2	2	1	1
Phoenix, Ariz.	84	49	20	6	4	5	4
Pueblo, Colo.	19	12	5	2	-	-	1
Salt Lake City, Utah	40	24	8	2	2	4	1
Tucson, Ariz.	99	59	28	7	5	-	8
PACIFIC	1,977	1,254	381	174	81	81	89
Berkeley, Calif.	15	14	-	1	-	-	-
Fresno, Calif.	61	34	13	7	3	4	7
Glendale, Calif.	20	11	7	2	-	-	-
Honolulu, Hawaii	58	39	15	2	1	1	2
Long Beach, Calif.	116	72	27	6	1	10	10
Los Angeles, Calif.	638	390	124	72	34	12	21
Oakland, Calif.	82	51	13	10	3	5	3
Pasadena, Calif. §	36	34	-	1	-	1	1
Portland, Oreg.	106	67	19	8	8	4	7
Sacramento, Calif.	126	81	23	12	4	6	11
San Diego, Calif.	125	83	18	8	8	8	5
San Francisco, Calif.	152	86	32	21	2	11	1
San Jose, Calif.	158	103	31	11	8	5	9
Seattle, Wash.	173	108	40	9	6	10	7
Spokane, Wash.	57	38	13	1	2	3	1
Tacoma, Wash.	54	43	6	3	1	1	4
TOTAL	12,240††	7,991	2,511	934	373	421	591

* Mortality data in this table are voluntarily reported from 121 cities in the United States, most of which have populations of 100,000 or more. A death is reported by the place of its occurrence and by the week that the death certificate was filed. Fetal deaths are not included.

** Pneumonia and influenza.

† Because of changes in reporting methods in these 3 Pennsylvania cities, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.

†† Total includes unknown ages.

§ Data not available. Figures are estimates based on average of past 4 weeks.

RSV Outbreak — Continued

Reported by L Corey, MD, A Cent, B Harrison, Children's Orthopedic Hospital, A Downing, MD, R Doan, MD, R Finger, MD, J Kobayashi, MD, State Epidemiologist, Washington State Dept of Social and Health Svcs; Div of Field Svcs, Epidemiology Program Office, Div of Viral Diseases, Center for Infectious Diseases, CDC.

Editorial Note: RSV can be responsible for outbreaks of serious respiratory illness in all age groups. Although it infects nearly all persons by age 2, reinfection occurs throughout life (*1*). Serious illness most often occurs among children under 2 years of age, for whom RSV is the leading cause of lower respiratory tract illness. In this age group, RSV can be a serious nosocomial pathogen (*2*). In one study, hospitalized infants and young children who become infected with RSV had nearly a twofold increase in length of hospitalization (*3*). Children with compromised cardiac, pulmonary, or immune systems are at greatest risk from RSV infection. A mortality rate as high as 37% has been reported among hospitalized patients with cardiac abnormalities who became infected with RSV (*4*). Outbreaks among the elderly in nursing homes have also been associated with serious illness and some deaths (*5*). In older children and adults, RSV most often causes an upper respiratory tract illness, often with fever; but otitis media, exacerbation of wheezing in asthmatic patients, altered airway reactivity in otherwise normal individuals, and lower respiratory tract illness also occur (*6*).

The basis for an association of illness with shorter duration of residence at the institution is not clear. One possible explanation is that those residing at the institution longer had experienced more RSV infections (because they were older and possibly because they had more frequent exposures to RSV infections) and, therefore, were less susceptible to infection or illness with additional exposures (*1, 7*).

Institutional outbreaks accompany the yearly epidemics of RSV in the community. In the United States, these yearly community epidemics occur sometime between late fall and early spring and last 2-5 months. After introduction into an institution, RSV can spread by close contact or fomites, and staff members may be involved in this spread either by inadvertently carrying infectious material from one patient to another or by becoming infected themselves. Recommendations to control spread of RSV in hospitals include strict attention to good handwashing practices and the use of gowns when contact with respiratory secretions of RSV-infected patient is likely (*8*). Infected patients should have private rooms when possible or be cohorted with other infected patients (*9*).

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Acquired Immunodeficiency Syndrome: Meeting of the WHO Collaborating Centres on AIDS

Following a consultation on acquired immunodeficiency syndrome (AIDS) in April 1985, the World Health Organization (WHO) established a network of Collaborating Centres on AIDS to provide a framework for international cooperation, including training, provision of reference reagents, evaluation of methods, and epidemiologic surveillance (*1*). The directors of the WHO Collaborating Centres, together with other experts in virology and public health, met in Geneva, Switzerland, September 25-26, 1985, to make recommendations for WHO's 1986-1987 international activities on AIDS.

Participants at the meeting reviewed the epidemiologic status of AIDS and affirmed the disease was now a major public health problem in several countries of the developed and developing world. Over 13,000 AIDS cases were reported from 1981 to September 1985 in the United States, and the number of reported cases will probably double in 1986. More than 2,000 cases have been reported from 40 other countries. The Director-General of WHO expressed the great degree of concern felt in almost all 166 Member States of WHO regarding AIDS.

In the United States and western Europe, approximately 90% of cases among adults continued to occur in homosexual and bisexual men, intravenous drug users, and sexual partners of persons in these groups. Although it is expected that additional AIDS cases may develop in recipients of blood and blood products who are already infected with the causative virus of AIDS, lymphadenopathy-associated virus/human T-lymphotropic virus type III (LAV/HTLV-III), future infections from blood and blood products can now virtually be considered preventable by screening blood donations for evidence of antibodies to the virus. Most pediatric cases of AIDS have occurred among children of persons in known risk groups. In several developing countries, however, most adult AIDS patients have been sexually active heterosexual men and women.

There is no evidence that LAV/HTLV-III is spread through casual contact with an infected individual, such as contact in family settings, schools, or other groups living or working together. The risk of infection of health-care workers seems very remote. At present, there is no evidence that blood-sucking insects transmit the disease.

The group concluded that an internationally accepted case definition of AIDS, relevant to its most severe clinical manifestations, was needed for surveillance purposes. For therapeutic trials or other research purposes, broader definitions may be required.

In countries where appropriate technologies are available, the surveillance definition for AIDS given by CDC and published by WHO (*2*) was endorsed by the group. Surveillance definitions are now being developed for use in countries where access to diagnostic techniques is limited.

The group concurred on the following issues:

1. For routine, large-scale testing for AIDS, the only practical methods currently available involve tests for antibodies to LAV/HTLV-III.
2. All sera reactive for anti-LAV/HTLV-III antibody in a radioimmunoassay (RIA) or enzyme-linked immunoabsorbent assay (ELISA) test should be confirmed by an independent test system, e.g., by immunoprecipitation or immunoblot tests. Assays for this antibody of higher specificity but lower sensitivity than that of conventional commercial ELISAs may be more appropriate for seroepidemiologic studies where confirmatory tests are not available.
3. Posttransfusion AIDS can be eliminated by excluding donors from groups at increased

AIDS – Continued

risk of infection and by screening all units of blood for antibodies to LAV/HTLV-III. Because infection can be transmitted from women to babies during the perinatal period, women who are antibody-positive should be advised to avoid pregnancy.

4. Reusing unsterile needles carries with it the risk of transmitting AIDS and other blood-borne infections. This procedure should be strongly discouraged.
5. The possible transmission of infectious diseases through the use of jet injection devices was discussed. After considering the available information, the group concluded that there was no evidence of a risk of transmission of blood-borne infection from using such devices.
6. Studies to identify effective therapeutic regimens for AIDS patients and work on developing vaccines are in progress in several countries. Successful therapy may require a combination of antiviral agents and substances that enhance immune responsiveness. Passive protection against infection is being pursued experimentally, including the use of monoclonal antibodies and hyperimmune gammaglobulin. Further work towards understanding the role of antibody in preventing and treating AIDS is required before these substances can be utilized in patients.
7. New antiviral drugs require careful study using the procedures of classical drug-evaluation protocols, under the guidelines of national control authorities. Studies to define the pharmacology, toxicity, and tolerated dosages must precede studies to determine the benefit.
8. Placebo-controlled studies in patients with mild forms of disease due to LAV/HTLV-III infection should be encouraged. Such studies will yield an answer on the efficacy of a drug more quickly and with fewer patients than the use of historic controls.
9. The prevalence of AIDS will depend heavily on the success of risk-reduction programs based on public information and education.
10. Because patients infected with LAV/HTLV-III often have immune-function abnormalities, administration of the commonly used live-virus vaccines (e.g., polio, measles) to such individuals could pose a theoretical risk. However, to date, no unexpected adverse reactions have been noted in individuals with antibody to LAV/HTLV-III, and such patients are free of overt signs of clinical AIDS when given the vaccines recommended by WHO for childhood or adult immunization programs.
11. T-lymphotropic retroviruses of simians provide potentially valuable models for studying the control and treatment of AIDS (*3*).
12. An important aspect of WHO activities on AIDS will be the collection of data on the incidence of the disease or its causative virus by Member States and the WHO Collaborating Centres and the regular transmission of this information to WHO headquarters. Wherever possible, information on the gender, age, recognized risk factor (if any), and major clinical features should also be provided

A full report of the meeting is available from the Director, Division of Communicable Diseases, WHO, Geneva.

Adapted from WHO Weekly Epidemiological Record *1985;60:333-5.*

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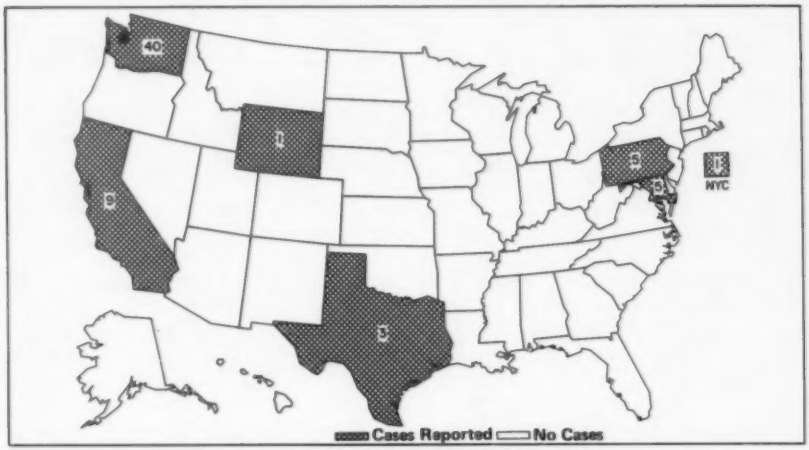
Influenza Isolate — Texas

Type A(H3N2) influenza virus, the first influenza strain reported from the United States this season, has been isolated in Houston, Texas. The virus was identified in a throat specimen collected October 4, 1985, from a 7-year-old Houston resident who had fever and upper respiratory illness. The child's illness was a sporadic case, and no further influenza virus isolates have been obtained.

Reported by Influenza Research Center, Medical College Baylor University, Houston, CE Alexander, MD, State Epidemiologist, Texas State Dept of Health; Influenza Br, Div of Viral Diseases, Center for Infectious Diseases, CDC.

FIGURE I. Reported measles cases — United States, weeks 40-43, 1985



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